Section 4. The case studies
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In this Section we describe seven case studies based on observations at the two courses that RP observed – Highville (the Balint group) and Jamestown (the non-Balint group). Both groups and their associated teaching hospitals serve heterogeneous areas characteristic of most inner cities. In view of the dialogical nature of ethnographic research, parts of this Section are written in the first person.

Highville

Highville has maintained a Balint group within its VTS programme once a month, with the aim of *'getting participants to see things from both sides – the patient's reality and the doctor's reality. How to make those two bubbles come together?'* Two course organisers, Dr Scorso and Dr Adamson, both of whom have been active in the Balint Society for some years, lead the group. They'd found that weekly Balint sessions had run into *'some negative feedback'*, so the monthly session, with the afternoon devoted to one or two key presentations and follow up cases – perhaps the most popular part of the half-day release course – was a workable compromise. It was not *'pure Balint'* they pointed out. But the approach dovetailed comfortably enough with their job description: *'to turn out reflective practitioners at the end of the year'*, Dr Adamson noted.

Registrars and SHOs came and went during the research. Yet, by the final visit, a sense of who the key players were began to emerge, and group cohesiveness was achieved amongst the 13–17 doctors normally present, despite the turnover. It was a large group to handle, but size had its compensations, enabling a diversity of opinions to be expressed. Sitting opposite one another and *'watching each other like hawks'*, Dr Scorso and Dr Adamson were alert for the slightest slippage of emotion within the group.

Dr Scorso hoped that the research wasn't going to be *'a knee-jerk response'* to what were initially intended to be only two visits.

Jamestown

This VTS was responsible for a large group of over 30 trainees who were split into three groups, two for registrars and one for hospital SHOs. The more intensive group work, therefore, relied on smaller numbers than at Highville, and the two GP course organisers changed groups after six months to enable registrars to gain experience from different leadership styles. My two observations took place with Dr Fitzjohn as course organiser. He had not long been in post. The maximum group attendance of seven or eight fell to four on my second visit.

The weekly, one-hour, group sessions, held towards the end of the afternoon, were expected to be 'more general and spontaneous' than either the conventional tutoring that had preceded it, or the MRCGP study groups that registrars were encouraged to form, with rooms being set aside during the holidays for the purpose. Interviews suggested that, with pressure from exams, the loosely structured case discussions of the previous year had given way to clinical matters; they were *'the icing on the cake'*.

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The following section presents a series of case studies that, although specific to time and place, illustrate different but interlocking aspects of the group work experience. Case studies illustrate particular themes and, in the ethnographic sense, can refer to an entire research site. They do not necessarily relate to one or more individual patients, in the way that doctors may understand the term.

The first speaks to a familiar concern for doctors: the difficulties of establishing appropriate boundaries between patient and doctor, and the anxieties when these are breached. The case illustrates, too, the shifting notions of public and private that doctors learn to negotiate within the group, and the way emotions are, in the best sense, performed.

Case 1 (Balint group): the personal and the professional – 'I'm a soppy *person* but not an emotional *doctor*'

Dr Lytton, a young female doctor, had moved with her family from South East Asia and joined a practice in England. Becoming involved with one of her patients had left her uneasy at the depth of feeling their relationship had kindled. This was a case with a difference, she thought: *'It's more to do with it puzzling me, than being the usual heart sink case. I'm bringing it up just because of the emotions it arouses.'* I'd expected the presentation to run dry after about five minutes, but the story was still unfolding after fifteen. Neither were there the anticipated hesitations and circumlocutions, the delivery being poised and fluent, attributable, perhaps, to the years of case presentation training in medical school. The gestures and body movements that might embellish telling a story to a group of friends in a pub were absent here. Only a slightly clenched fist betrayed any hint of effort, although she worried at teatime lest her voice was hoarse, and her eyes fixed on the carpet rather than being directed at the group. The presentation made a demand on performance.

Words don't stand for objects. Dr Lytton's story wasn't merely imitating reality; rather she was *'giving a flavour of things'* in order to communicate. The result was powerful and absorbing – an intense experience in which the group captured something of the messy process of reaching over into another person's world.

A story that could be tried on for size, it 'began' with the patient's first visit to the surgery, and 'ended' with her

return home. At the end Dr Lytton wept quietly: *'I wouldn't have told this story if I'd known I was going to break down.'* Describing herself later at interview as *'a soppy* person *but not an emotional* doctor', she was dismayed to find herself caught off guard on the patient's last visit. *'Before I knew it, I was crying. I couldn't believe it! I was embarrassed I was crying, because she wasn't!'* – an imbalance that elicited a warm ripple of sympathy from the group. The series of double appointments, booked by the patient at two-week intervals, had left Dr Lytton behind with the rest of her list, and the group warmed to the difficulties of handling her patient's farewell request for her email address:

'This woman hasn't taken on board what's happened in an emotional way, and Dr Lytton is doing it for her', commented one.

'She didn't come to you for a medical thing. She came in and asked to be referred to a psychiatrist, and then she finds this incredible empathetic person', another volunteered. *'She's someone who goes through her emotions quite quickly, buzz, buzz, buzz.'*

'She's a whirlwind', commented Dr Adamson.

'Wasn't she angry?' Dr Scorso wondered.

The story could be told differently. A comment from another registrar at interview suggested another perspective: *'She was apologetic, but I was thinking "no, no, no". It's wonderful. It's one of the privileges of medicine and the joys of it. I felt she wasn't seeing it for the beauty it contained.'*

At interview, Dr Lytton gave a more robust account of the patient, one less exercised by the need to repair her professional identity; the same situation had many different readings. *'I thought maybe she is seeing me more as a daughter than a doctor, the way she poured out her feelings. The more I thought about it, the more I thought there's a closeness there to the patient that you couldn't explain just because you were familiar with someone. But I was uneasy.'*

She was worried, too, that she had overdone the bond with a patient from her own background. *'In my presentation I put it that there was a special bond, I don't know whether it's because she's from the same country. And then when I said that I thought "Oh my God, I wish I hadn't said that". It's not really ethically correct. You know you have a special bond* just *with people who are the same as you. I always play down the race thing.'* This was not a story ripe for telling in the group, as comments from other registrars about insensitivity to ethnic differences within the profession indicated.

Later on, Dr Lytton received the affirmation she was seeking with *'a lot of positive feedback'* from the group, one member commenting *'I felt like crying too.'* Another said *'I didn't want to say it in the group but that was one of the most beautiful stories I've ever heard.'* Dr Scorso gave her a hug.

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When I returned the case study for Dr Lytton to comment on, she remarked *'It's very good.'* This was certainly gratifying. However, when doctors had complex and often contradictory responses to Balint work, it would be remarkable if they didn't also have similar reactions to a researcher's writing about their engagement with it.

Discussion

The case centred on the familiar theme of monitoring the boundary between the professional and the personal – and the anxiety with which such boundaries are constantly screened within the profession. Salinsky and Sackin[3] draw attention to the costs of failing to distinguish clearly between the two. Exposure, though powerful, is also dangerous.

Yet doctors do get close to their patients. Moreover, in siphoning things off into separate compartments, Dr Lytton had to repress the natural spontaneity she felt towards a patient with whom she had a strong fellow feeling. The unemotional person may risk becoming the unfeeling doctor.

Whilst Balint methods carefully eschew telling group members what to do, the social drama being enacted here suggested that professionally appropriate norms of formality were being more subtly inculcated; boundaries were being publicly reaffirmed in the group, whilst privately allowing registrars to think more fluidly around them at interview.

The case also points to the way that interpretations are potentially infinite; whilst drama seeks resolution, life does not – there was no *'complete picture'* or resting place that some registrars in the group still searched for. Dr Lytton was also balancing the actualising, goal-oriented, 'Western' self with the more communitarian understanding of the person in the 'East'. At stake too were the difficulties of using Western concepts to describe other people's emotional patterns, an issue to which doctors in other sessions drew attention. Culture bites.

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Case 2 (non-Balint group): 'You can get more out of these sessions than from any textbook'

Boundaries of a different kind animated this second case, which draws on observations at Jamestown and an interview with one of the presenters. It illustrates the difficulties hospital-trained doctors may have in adapting to 'the grey zone' of general practice, where illnesses do not necessarily fit neat diagnostic categories, and where communication is a question of learning to read between the lines. Narratives of illness (rather than disease) opened up different possibilities.

The course organiser opened the session with *'Does anyone have anything they'd like to talk about? Any situation that's bothering them?'* Strongly articulated within the group was the desire *'to do better'*, a powerful theme in professional development.

Dr Norton was the first presenter, seemingly too young to be responsible for the complex health needs of the mixed community served by her practice. However, appearances were misleading and further acquaintance showed a resilience and commitment to enhancing her competence. She described the situation that had been puzzling her – hesitantly at first, and then, sensing the warmth of the group, with increasing confidence.

Her patient, a young girl with learning difficulties, hadn't wanted her mother to know about her relationship with an older man, recently discharged from prison. Mother's and daughter's stories were at odds, the mother feeling her daughter needed antidepressants, the daughter in search of contraception. In pursuit of a single, coherent narrative, this was *'Not a situation I handled brilliantly'* Dr Norton acknowledged. *'I felt completely out of my depth. I just felt the girl might have completely lost confidence in me. She didn't know that I hadn't said anything to her mother. All she knows is that her mum was in here whilst I was talking to her.'*

But she had felt protective towards the young patient, *'I was on her side'*, and had decided to bring the case up, she told me at interview, to clarify in her mind the boundaries. Her big worry: *'To tell people negatives, like "I didn't do that", or "No I didn't give her an antidepressant", is that breaking confidentiality as well?'* She went on: *'I chose that one because I felt bad afterwards. And I want to feel better. So I learn how to do it better next time.'* Self-improvement was a key motivator.

As a young GP committed to exercising her responsibilities towards her patients, she found the group provided a forum to listen to different views. Yet the group response was similar, agreeing *'It's much easier to do things on a one-to-one basis'*, and that she hadn't *'done anything wrong'*. Whilst she half-wondered how honest her peers were being, she acknowledged *'It's nice to get your colleagues' feedback that they thought you did all right. It was also nice that they didn't have anything else – they didn't really know what to do either in a way. It's something that you have to deal with as it happens.'* Still quite new to the experience, she was discovering the limitations of medical textbooks. Perhaps being an effective GP meant thinking more divergently too?

The following week the group had reverted to discussing traditional clinical topics – *'It wasn't really like* [the session] *you were there for'*, Dr Norton pointed out when interviewed. Neither was it a situation the course organiser was happy about. To the group's selection of a topic for the following week, he had commented: *'I think you're choosing that because you're finding it easy to talk about because it's all practical. It's what you know, it's what you like.'* Dr Norton reflected: *'And it's true really. You can't get that out of any textbook. You can get more out of those sessions really.'* An unspoken question hung in the air: did talking about a case in this way constitute proper learning?

Nevertheless, the group experience was a safe haven for Dr Norton – refreshingly different from the larger group of 30 trainees where she was too anxious to speak out. Perhaps in time that might be turned around too?

Discussion

The group discussions provided a brief, but powerful, forum where more fluid notions of the consultation were being presented. Newly in post, registrars were finding that the boundaries between science and art were contestable, the 'right' answers more elusive, and the parameters to the doctor–patient relationship more complex than anticipated.

Trained to do one job, Dr Norton found that her skills didn't necessarily equip her to deal with the variety of situations facing her. A more divergent way of thinking about patients was being revealed. The group could be profoundly liberating.

At the same time, there were constraints to Dr Norton's learning. Stories don't arise *de novo*. Rather than 'raw experience', what she selected drew on shared understandings that simultaneously provided recipes for thinking about similar cases in the future. Whilst some boundaries were being questioned, others were not; for example the group didn't touch on how both the doctor and the patient's mother might be caught between promoting 'normality' and fears of causing difficulties, reflecting wider social ambivalence towards the sexual activity of learning-disabled people. In *'taking sides'* was she transmitting as well as reflecting preferred values where medicine keeps a protective eye on sexual behaviour?

In going public she was also learning to monitor her own conduct. Group work was empowering – understandings could develop over time. But it was also powerful at creating conformity, without appearing to do so; *'people do tend to become more like each other'* as her colleague mused. The group was an important space for being creative, but within a frame.

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Case 3 (non-Balint group): a view from the course organiser's seat

This case study shifts the centre of gravity to explore what Dr Fitzjohn, the course organiser at Jamestown, was trying to put across. Subject to many similar pressures as those in his charge, his deliberations point to the difficulties of standing simultaneously inside and outside the educational task.

Disillusioned with the impersonality of a surgical job in hospital medicine, Dr Fitzjohn had found himself drawn to general practice. From there it was but a short step to becoming involved in postgraduate training.

Although he had not been a course organiser at Jamestown for long, his softly spoken manner had already left its stamp on the small-group work that had been initiated there. The question was: how to temper the severity of the moral judgements his registrars often made about patients, to *'get them to be a bit more forgiving, to ask them to think of patients as people. Often if a patient is late, it's "they're lucky to be seen" kind of thing. Some registrars have a very black and white approach to things. Druggies, for instance, are seen in terms of "a lack of moral fibre". It's in the Native American saying – "never criticise a man until you have walked in his moccasins".'*

This was the theme of one of the small groups visited, where doctors wrestled with the problem of responding sensitively to the culturally diverse mix of patients who passed through their surgery doors. How to deal with the unsettling realisation that 'they think differently there'? An older New Zealand registrar talked about her frustration with an Egyptian patient who *'wasn't taking responsibility for his diabetes management'* and who

'cluttered the consulting room with his children'. Dr Fitzjohn's response – *'that in Eastern cultures, the whole family is involved'* was encouraging rather than provocative. It paid dividends. Five minutes later the response softened: *'I was failing to communicate the seriousness of things in a way which he could understand, knowing that his life was going to be shorter and made less enjoyable. It's a human level really.'*

He was also keen to foster, particularly amongst his male registrars, *'a bit about looking at their own emotions, recognising those projected from their patient. Very simple stuff, but it's a different way of looking at things.'* Not of a psychoanalytic turn of mind, he found Transactional Analysis (TA) and the Cambridge–Calgary consultation model useful explanatory tools. *'It's Pendleton and beyond'* he explained. *'It's an evidence-based consultation technique – let the patient talk. We're doing an extension of that, but we don't make the theory too explicit.'* Some accessible handouts in the office on TA attested to this. One registrar at interview commented how she'd found the theory *'a useful peg to hang things on'*, although Dr Fitzjohn pulled a wry face at the difficulties many GPs have with theoretical concepts.

The emphasis on mother and child, and the feelings registrars projected on to their patients, had some similarities to Balint work. *'Yes I expect there are elements, but it's only a very simple part of the parent–child relationship. We're not a Balint group – although it's a matter of terminology. I think Balint was the first person who looked at the consultation as a tool in itself, and the things that came from that are still useful and valid. But I think Freudian-type things are somewhat discredited now. We've moved on.'*

Nor was he overly enthusiastic about weaving Balint training into his programme. With a careful eye on responding to what registrars said they wanted from their postgraduate training, he considered *'It's* their *agenda. If the registrars said "yes", then we would. But my feeling is that it's too prescriptive, too rigid, too prescribed, too time-consuming. There's so much that registrars have to do in their year. I don't think you should be limiting them to one particular approach.'* The trouble was the registrars interviewed had not heard of Balint training. What was on the agenda for registrars to choose from was still largely in the hands of the course organiser.

Dr Fitzjohn was shyly pleased with the balance struck between the didactic and pastoral aspects of his role. However, his invitation towards the end of the small-group work that afternoon for registrars to talk about any practice difficulties, or problems with their trainers, met with some discomfort. The example volunteered – *'When everyone's staying on in the practice through the day, I can't go off to the gym for an hour. No one actually* says *anything'* – was followed speedily by *'Oh no, I'm not wanting to complain'*, and embarrassed laughter from the group. Such difficulties were more likely to be addressed on a one-to-one basis. Still, Dr Fitzjohn considered that more group work would be better. *'You could do problem-based learning (PBL). You could look at some of the dilemmas, some of the models.'* Lecture-based formats, on the other hand, *'make our lives easier. They're comfortable with that, it's what they're used to, and the Deanery expects it.'*

One of the small successes of his group work he felt came from the fact that *'At the beginning of the year, registrars rate the diabetic consultant who comes to give a lecture highly, but the rating is quite a bit lower by the end of the year.'* While putting ideas to work is rarely straightforward, might this nonetheless be a pointer? His reply was cautiously optimistic: *'I'd like to think so.'*

Discussion

Like the Balint group, this was a drama with a moving script; important values were being inculcated here, without seeming to be so, although Dr Fitzjohn explicitly intervened more in the group than his colleagues at Highville.

There were ambiguities for Dr Fitzjohn in being both educator and practising GP. However non-directive the facilitator, the educator is always ultimately the curriculum. Being responsive to *'their agenda'* did not mean that the groups were without a script, and the question of how best to navigate the dilemmas of friendly power were ever-present. Similarly, while he was well versed in the nuts and bolts of everyday practice, questioning his own value system, which is also at the heart of the educational process, is difficult at the best of times, a tension that also surfaced at Highville. He had to tread warily for other reasons as well: as advocate for his registrars, narratives about personal and practice problems might stray. There were limits on what could be divulged within the group.

As Dr Norton indicated, it was difficult to keep the spontaneous group discussion going under the pressure of other demands. The more disciplined structure of Highville may have important advantages here, although be less responsive to the imperatives of self-directedness.

In concentrating on what learners are supposed to be learning, it is important not to neglect what teachers are trying to transmit. Understanding the constraints and possibilities of a course organiser's role is all part of the picture.

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Case 4 (Balint group): 'It's fantastic to do something in depth'

This case gives another perspective on the nature of the group experience, so we can better understand what doctors thought they were learning. It enables us to see the complex and contradictory nature of the conversations doctors were having with themselves and with each other, something that is at the heart of the Balint process.

The distant hum of traffic on a warm summer's afternoon in the park provided a tranquil backdrop to the interview with Dr Malek. She brought an insight and alertness to our discussion that was a delight. Developing sensitivity to the contexts in which patients lived out their lives was one of the highlights for her from her year's experience in the Balint group at Highville. *'I think it helps you remember that the patient belongs to their life, to their circumstances and to the community. We only see patients in the consulting room'* she mused. Moreover she was able to draw intellectually on the resources of other

group members: *'It's helpful because you have the combined energy and intellect of the whole group adding ideas, and that's great. You can all draw analogies between your patients and their patients.'* The depth of coverage and attention to detail was invigorating too; it marked the group out in her mind as intriguingly different from previous experiences.

She'd been affected by Dr Lytton's earlier presentation. The difficulties of setting appropriate professional boundaries resonated with her own experiences as an Indian doctor. *'I just feel that if I have a South Asian patient who's older than me, I find it difficult knowing where I stand. It's not a normal situation for me. They will approach me as a niece and be friendly to me and ask about my family and background, which I don't have a problem with actually. It's just different. An English person wouldn't approach you in that way. I think I see patients as an aunty too.'* The consideration displayed was also a contrast to her experience overseas where *'the doctors treat the elders in a very condescending manner. And patients expect it. I'm not comfortable with that.'*

Reality is many-sided. Despite her enthusiasm for Balint training, Dr Malek had some reservations. *'It's hard work, you're thinking so hard. Quite a few people in the group don't like Balint actually. They find it boring. I think they wonder what the point of it is. I think that's because in the group we stop at what's going on between doctor and patient. I don't think you find the conclusions or the solutions or the way forward. That's what would make me find it more useful.'* In a solution-oriented profession, it was hard to appreciate that solutions often lead to new problems, not to mention the further step of learning that the best solutions are often those we find ourselves.

There were other concerns: was she biting off more than she could chew? *'Patients didn't ask us to psychoanalyse them. Sometimes I wonder is it any of our business? I'm very private about myself with my GP. If I had someone think about my psyche . . . '* – she trailed off.

She was one of the livelier SHOs in the group and had read something about Balint. However, she was puzzled: *'My understanding of Balint was that you're in a group to discuss a case and use the method of transference and counter-transference to find out what's going on. And it wasn't that, and I couldn't understand it.'* The experience needed a language within which to frame it. The distinctiveness of Balint was not self-evident: *'I think it would be helpful to have some idea of what Balint* was *so you could have some sort of an aim.'* She wrinkled her nose in concentration: *'Well, no one knows what it is. Only the GP group that I go with knows what it is.'* Her reading and the group experience didn't tally: *'Balint isn't just about studying a case in detail. It's about thinking in a certain way about it.'* Perhaps there was more than the one version? *'I think every Balint group is different. I've talked to people who've been to other Balint groups and I don't think there's a dead set formula.'*

Explaining what Balint was to newcomers in the group over the year had led to some misunderstandings. Mostly the group had been respectful, but she had found herself bruised on one occasion: *'I made a comment about a patient who had sexual problems and her husband had been unfaithful to her – she's not* doing *anything, she's passive, passive – and it didn't go down well in the group. It was quite hurtful. I think the group thought I was being unsympathetic but I wasn't. I was trying to figure out what was going on. I took it literally that that was what Balint was about, but I don't think the Balint we do is really about that.'*

But a critical impression was not one she wanted to leave me with: *'Maybe I'm being too harsh.'* She enjoyed the groups, and derived an important sense of belonging from them. She was wondering whether to pluck up courage to present a case that had bothered her: a tricky situation where the relative of a patient she was clerking in A&E turned out to be a doctor who subsequently criticised her management plan in front of the patient. However, like all SHO consultations, this was a 'one-off', which didn't have the continuity of care more typical of GP presentations within the group. When RP first visited the group SHOs contributed to the discussion but did not present, learning *'naturally'* from their more experienced colleagues. Later, following discussion at a trainers' meeting, they started to present their own cases.

Her Balint experience was likely to prove fertile. Wanting to combine clinical medicine with an arts foundation course – *'pure indulgence'* she laughed – her appetite to think more broadly about things had been whetted. Life was full of promise.

The situation changed during the course of the study. On my fourth visit, Dr Malek made a full-length presentation to the group: not the one she had in mind at interview, but about a patient from abroad whom she'd been upset by in casualty because he was without the close supportive network she'd come to expect. Later still, she clarified her puzzles about Balint: *'It's not something that's on paper. It's what you make of it personally that counts. That's what I meant to put across.'*

No sooner secured on the page, understandings were capable of infinite re-description and enhancement. The written page inevitably seals meanings, but meanings are always unravelling.

Discussion

For a young doctor eager to stretch herself, the Balint experience had proven to be exhilarating. Bringing disparate experiences into the same social space jostled the imagination.

The case articulated dilemmas in postgraduate medicine that were not new: the push and pull between being and doing. Yet doctors have to work in a profession still ill at ease with reflection and theory, and in a solution-oriented culture where medicine is often the victim of its own success. Self-doubt was hardly surprising when doctors found the hard-earned tools of their profession didn't always meet patients' needs.

This was a Balint group with SHOs as well as registrars. Despite the egalitarian ethos of the group, traditional hierarchies filtered in here too; it was expected that SHOs would learn from GPs' greater experience, although registrars were often surprised at the depth of understanding of their hospital colleagues. Had the

'brutalising experience' of hospital training suggested by one GP not left its mark after all? Interviews with other doctors suggested that Balint training may be less grounded in SHO experiences. The question of 'for whom is Balint training most relevant' – indeed, as one registrar asked, *'Who owns Balint?'* – prompted the difficult question of how far Balint's important roots in general practice could inform other contexts and specialities. Widening the basis of what constituted a case risked diluting its message. Failure to do so risked reducing its appeal.

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Case 5 (Balint group): 'There's what you say in the group, and there's what you say outside'

Dr Sanju's story illustrates the multi-layered nature of openness in the group. Whilst many doctors appreciated the chance to explore things in the comparative safety of the group, trust was a moveable feast, as doctors negotiated what character flaws they could reveal, and where discretion was the wiser policy. The perceived similarities between Balint and other group work were also apparent.

A doctor with a strong mind of her own, Dr Sanju had taken a sideways career move into hospital management. With two young children to bring up, she wanted to *'get a life'*. Now things were more settled, she planned to move back into general practice and had joined the Highville VTS with this in mind.

Her experience of group work to date had been positive, although it wasn't always a straightforward matter of remembering what had been learned where. Generally, though, *'I was surprised how the group used to open your eyes to things. . . . Maybe I'm an unusual person, but I was brought up differently to a lot of people. How I would handle a patient isn't necessarily how most people would.'*

A vivid case scenario that her group had discussed during their ethics training elsewhere had jostled her imagination: that of a terminally ill patient where the husband effectively asks the doctor to help her die. The dilemma presented was: how to respond to the phone call about the patient's death, realising that rather more morphine had gone than perhaps should have been the case. *'To be honest with you, my thought initially was I wouldn't say anything. What would it gain? You don't know either. There could be all sorts of reasons for the discrepancy. You've got to give them the benefit of the doubt.'* At first she'd been impatient with the group's anxiety about signing the death certificate: *'Oh for goodness sake, he's not a murderer. You've got to distinguish between someone who'd kill their wife and someone who's just wanting their relief, whatever.'*

However, dilemmas have many shapes and forms, and she'd been intrigued by some of the arguments. *'That's what I mean about the learnt process. When you first start off in the group, you bring ideas and you get this – "mmmmm, mmmmm". "No I wouldn't do this." "Oh I don't think that." You think, "Am I the only one there who* thinks that?" You don't want to be the only one who thinks that.'

This partly rubbed against the image she held of herself as something of a rebel: *'I'm very much an, "I don't care what you think about me" person.'* Yet, returning to the case scenario, she reflected *'If they were all shocked about it, "ooooh, you mean you'd* lie?*" I'd try to redeem myself. You'd sort of pick up on it, and* not *be this awful doctor who'd lie on the death certificate.'* Group pressure was not only a powerful constraint; there were also more complex issues at stake that she had too readily brushed aside. *'It does make you think about it'* she mused.

The question of emotional honesty troubled her. She recalled the group's last feedback session to the course organisers at the end of term – a favourable outcome, although both Dr Scorso and Dr Adamson had questioned it at a leaders' group afterwards. *'People aren't being honest'* Dr Sanju reflected. *'We're asked to say what we've liked. Everyone says "Oh yes", But outside . . .?'* More straight clinical teaching would have suited her tastes better. What was she to do with the alcoholic patient who beat up his wife? Stepping back to think rather than rushing in to solve problems didn't always sit comfortably with the way she had been trained.

However, her Balint training to date hadn't been in vain. *'It allows you to – not accept everyone else's opinion, but at least open your mind to the world because everyone's coming from a different angle. That's the positive thing about it. That's the basis of what this is, to make holistic people. Not to change people, but to make holistic people.'* It was an enriching process, she thought, not one seeking to make fundamental changes in personality.

For her, Balint training wasn't inherently different from other group work she'd done earlier. It could be read simply, without having to delve into its theory. *'It's the same sort of thing as I've been doing all the time. You have a situation, what would you do? What do you feel? What triggered you to react the way you did to it? You just put a name to it. . . . I've been doing something roughly like it for the last five years.'* Analogies with clinical governance came readily to mind: *'We've been doing that for years. The fact that someone comes to put a name to it actually makes it* more *confusing. Everyone's running round trying to put it into a formula.'* It was the common threads in her learning that helped her weave her way through a complex world. Perhaps things were, after all, of a piece?

The hour was up. A new batch of emails had arrived on her desktop. Hers was a busy life with time to reflect in short supply.

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She sent me an email about the case study I returned to her for comment: *'I'm sure everyone will recognise it is me you are talking about, but to be honest I don't mind. I must say I never saw myself in such a light, but I suppose it's not a bad reflection of the way I behave.'* What to make of the paradox that she would be recognisable to others in the group, but, apparently, less so to herself?

Discussion

As with Dr Lytton, the performative nature of group work comes across well in this case study. The group was the arena in which to display an acceptable public face, whatever Dr Sanju's private reservations initially. In the process important professional and cultural values were being transmitted – and ideas transformed.

The anxiety about giving feedback also raises difficult issues for educators keen to understand how their efforts have been received. Other doctors, too, spoke of how they were sometimes *'too scared'* to say what they meant, or wished they could un-say that careless remark. Living in a culture where talk seems the solution to every problem, the tension between the apparent desirability of more open discussion, and the difficulties of this, are apparent.

Like other doctors, Dr Sanju had difficulty remembering what she had learned where. In the flow of lived experience she drew from many sources, a process at odds with attempts to establish clear boundaries between one kind of learning and another. Learning worked, or not, to the extent that new ideas folded seamlessly into older ones. How could one ever have thought differently? The psychoanalytic underpinning that gave Balint groups the edge was best left implicit here.

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Case 6 (Balint group): 'I found I had less and less to say'

This case also illustrates how everything relates to everything else, with few clear distinctions between one stimulus and another. It shows, too, how wary educators and researchers need to be of taking too literally what someone says as indicating inner reality: meanings were elusive. Many tales could be told about 'the same' thing.

Caught up in the sweep of events, Dr Ling had come to the UK as a refugee and the difficulties of integrating here continued to mark his life. Unusual, too, was his interest in weaving together ideas from the philosophy of science, quantum physics and Buddhism. Balint groups at Highville provided a fruitful arena in which to do so.

The patient he described at the group had a complex psychiatric history, and her parting words on their last encounter 'Goodbye, thank you and take care' had alarmed him. As he had listened to the complex story unfolding in his surgery – a dispiriting trail of different care homes, abuse from a father (or brother – or both?) – he felt increasingly at a loss; anything he had to say was almost redundant. His anxieties about the farewell greeting were not misplaced. A week later he told me the patient had phoned him after slashing her wrists: *'a profoundly symbolic gesture'* he thought.

He was pleased with the group's response: *'it's amazing, all these different ideas'*. Thinking about the experience generally, he commented: *'We put up with it and then actually get into it. We groan and moan and then we get into it. The groan initially is that we have to change pace.'* Other registrars, too, had mentioned how trying the apparent slowness of things was to adapt to. Effects were less tangible: *'Certainly. It's like a thin lining of butter on your toast. You can't quite pin it down. But it definitely does make a difference. It makes you more reflective and more able to face your own shortcomings.'* A little later he mused contrariwise: *'The process of opening your mouth and talking doesn't actually give you too much of an insight into what's happening behind the screen, as it were.'* Meanings were elusive. *'Life's like that. A mask is what we all wear!'*

The more academically oriented nature of Balint work in his psychiatry attachment had given him food for thought, but the individualistic model of the self that he felt underpinned all psychodynamic models didn't always fit comfortably with his other thinking. *'Balint is obviously Euro-centric, particularly as I'm an Asian. It's a construct basically. It's quite sanitised the theory, that's what I find. What is this process where doctors sit around? It must be very privileged. How does it affect us? Well of course it does, you know that. But how does it affect refugees? How does it translate into their life-world? How can I translate that to the refugee who comes beaten up and shot in the leg?'*

His questions had a sharp edge, as another case in the group had focused on the 'inappropriate' consulting behaviour of a Somali refugee patient – a situation that had annoyed the presenting doctor who found little to offer from her repertoire of tools. *'I wonder how much of that is Dr Parekh's* [the presenting doctor's] *conditioning without her being aware of it? . . . She's the gatekeeper, the shaman, the magic-maker and the totem-bearer growing up in an individualistic society where, hello, everyone's for themselves! The Western model, self-determination, blah, blah, blah, blah. Of course there are two worlds there. Two minds.'*

He thought of himself as reticent in the group. Not particularly because of any fear of criticism, but *'no one would understand what I'm talking about – the Buddhist fascination with all things running from the mind. The mind as mover, as it were. Jung taps that element too. Most of the time I hesitate to say anything because I'd just have to* explain, *and the group would have had to have thought about it.'* It was simpler not to complicate his relationships with others.

Chary of end-points, learning was a continuous process for Dr Ling. Nor was Balint about thinking in boxes. *'We've only learnt what's quantified, we've not thought about the impulses of our minds because at the subtle level, our mind is like quantum mechanics, particles moving almost randomly. If we don't have insight into that process – which Balint wonderfully explores. . . .'* (He trailed off, a half-formed thought perhaps.) *I believe that Balint is a dynamic, evolving, spontaneous process, not something that should be pigeon-holed. . . . '* In his excitement the words tumbled out. *'It should evolve, in terms of initiating a process which will let go of the pinning down, without any end-points. If you think in terms of end-points, it means you have to define start-points. Often things are vague, they're sort of quantum things.'* There were no easily definable compartments to learning, and conventional outcome measures were likely to mislead.

For the future? *'Whoooooaah! Balint* plus*!'* he exclaimed. *'Away from models of illness and models of psychoanalysis, to allow the development of a dialogue rather than just Balint and that's it – talking with people*

like yourself.' Flattery perhaps. Yet something more significant was at stake: the need to transcend the limitations of particular disciplines and ways of thinking.

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Observation at a later session revealed the difficulties Dr Ling had in putting the ideas generated in the group to work. Something had been said back at the practice, and clearer boundaries had to be set between himself and the patient he had presented. Openness wasn't a once-and-for-all accomplishment.

When I returned the case study to him for comment he said *'It's lovely'*, a compliment I've decided to take at face value – for the moment.

Discussion

The case is a good example of deep learning in action. Dr Ling was thinking analytically about the human predicament of his patient, and other refugee patients in his care, and about the group response. He was also thinking analogically. On the face of it, Balint, Buddhism and quantum physics had little in common. Or had they? A great deal when he started to consider things in more depth. The group work was a fertile – but not exclusive – source of ideas, continuously in play. Neither do people learn in complete units that can be recalled as wholes. Like Dr Malek and Dr Sanju, Dr Ling was sifting and selecting, the better to tailor things to his own purposes, and I learnt later that he practised acupuncture as well as orthodox medicine.

The Eurocentrism that Dr Ling pointed to didn't necessarily imply insensitivity to local values. Rather it highlighted the problems of trying to reach over into the worlds of others precisely because we are always confusing self and other. Doctors cannot but be bound by their own value systems, but they could reach across. The danger is that such systems may prevent them from understanding at what sort of angle they stand to the world.

The case also suggests that critical reflection is difficult to do on one's own. It is not simply a matter of individual abilities and dispositions. We do better in our conversations with others, particularly those who are unalike. We need to read things through difference as well as similarity. The best learning maintains the social conditions in which such conversations can occur. The talk is the learning.

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Case 7: a Balint group at work

This final case study explores the Highville Balint group at work over two sessions, one where the group fractured in disagreement over whether Balint work should include giving medical advice, and a session some weeks later where any apparent rifts were healed. Open friction in the group was rare; however, the case that doesn't go according to plan is likely to tell us more about what is happening than any number of typical instances.

The upset: is anything unusual going on here?

The group opened conventionally enough with two major presentations, both from SHOs. A fraught case had concerned a Somali patient in the hospital antenatal clinic, barely able to cope with the child she already had, and the prospects for her second pregnancy were not promising. Was it a question of abuse? Or was the group *'creating abuse where it doesn't exist'*, as one GP cautioned. More disturbing still, was it a way of settling accounts with a husband who abused her? Tension rose.

Dr Naroo was clearly exasperated: *'Why do we stop taking patients at their face value? We're sitting here speculating, fantasising, and neglecting the* hard facts. *It's a sort of Walter Mitty thing. I'd find it more helpful to ask what would you do? Have you checked her BP?'* Dr Malek disagreed: *'I don't think it's a bad idea to raise all these ideas.'* Dr Dyffed, the presenting SHO, remembered her own pregnancy: *'The point where you have a whole week with your baby, and two-year-olds are even worse, they can drive you to distraction.'* Perhaps doctors were closer to the edge themselves than they liked to think?

Dr Caernarvon, a registrar who was finding the transition from hospital surgery to general practice more demanding than he'd thought, intervened: *'All these different arguments, different ideas. I'm thinking in terms of training doctors. Is this lady hyperthyroid or not? We've not even mentioned medical advice. It's as though we're being steered away from it.'* Dr Scorso thought having a problem-based learning session was certainly worth considering (and ensuring high standards in clinical care was a high priority in the rest of the VTS programme). Dr Malek wondered if medical advice could be offered at the end of a Balint session? Not reticent in the group after all, Dr Ling reminded everyone of the Balint process: *'We don't like uncertainties. Even if you get the blood tests done, it's what you're pushing* away.' Perhaps conscious of the stir he had created, Dr Caernarvon apologised if he was being rude.

The group was aligning, and realigning. Heads nodded in agreement here; others gave little away. An evocative metaphor sprang to mind: Dr Scorso commented – *'It's about unpeeling layer after layer of stories. Can you afford just to stick to the facts? There's hundreds of stories, of envelopes unfolding.'* Dr Adamson, with customary imperturbability, said simply *'It's a powerful way of imagining.'* Dr Naroo pressed her case: *'You're making assumptions that just aren't true. It's a "let's pretend" session.'* Both she and Dr Malek had worried about invading patients' privacy: *'I've started asking questions, asking this person and that person what they do for a living, but people are becoming more private.'* It was time to compromise; Dr Adamson acknowledged that it was *'perfectly valid'* for the group to explore medical matters, but not to disturb the Balint process itself. The group digested this in silence. Then Dr Naroo, worried perhaps that disagreement might be disrespectful, reiterated *'I hope I haven't been rude.'*

Tea was an uneasy time: Dr Malek was upset, but Dr Naroo thought *'It's good to debate these things.'* In the toilet Dr Scorso wondered if she had a revolution on her hands, not surprising perhaps when a VTS group nearby had recently *'become dysfunctional'*. The group resumed

with a follow up from Dr Ling. With the end of the afternoon in sight, Dr Adamson invited the group to raise any medical issues. There was silence. Attempting to repair the discomfort, Dr Caernarvon ventured *'I'd like to meet someone with 20 years' Balint experience to see how they deal with all these social problems.'* It was both challenge and plea, but Dr Adamson let it pass. A comic story about a 'beware of the dog sign' at his last patient visit helped leaven the atmosphere and the group went on to discuss arrangements for Christmas lunch and a skating party.

At interview a week later Dr Caernarvon wondered if there was more to the 20-second rapid patient résumés he'd learned to do in hospital after all.

Harmony restored

Many of the same group members came to the next Balint workshop in the New Year and, as always, there was a good turnout. Of the two major presentations and three follow ups, one of the cases discussed concerned the tricky issue of the *'expert patient'* and the *'de-skilled doctor'*, a reversal that captured doctors' unease with threats to their professional competence. The young man in question, armed with *'a list of problems'*, came to Dr Sarton complaining of stomach ache. After checking his appetite, weight, diet and bowel movements, the discussion moved rapidly into worries about a heart condition, high blood pressure and shoulder pains: *'I wasn't getting anywhere with him, he wanted an X-ray form for his shoulder, and it was getting like "he can have this, but not that" kind of thing. I found him very frustrating, that a young and supposedly fit man comes in and says "I've got a list of things".'* The trouble was compounded when she found that he had already seen Dr Lytton in the same practice, and had failed to turn up for a blood test. Why, too, was he using the GP when he had a company doctor? A sticking point was reached over his diet: *'What is roughage? What is it* exactly?' he had asked. Unfortunately the practice had run out of leaflets, and Dr Sarton of patience. This was excess, and excess spelt disorder. The group engaged with the possible personality characteristics that might account for the behaviour. *'He seems quite a tense person who wants all his medical problems sorted out at once'*, commented one. Dr Adamson asked *'Why is this normal healthy man so b***** irritating?'* Dr Plaidy tried to put things in a wider perspective: *'We misunderstand their perceptions. He might be thinking "doctors are so busy, so whilst I'm here let's tackle the lot".'* But the question festered. Dr Loudon pointed to *'the way patients' preconceived notions trivialise doctors' knowledge. . . . What's the point of us having five years' training if all we do is write out forms?'* Dr Adamson left the group to ponder the *'de-skilling feeling which comes from patients'* who have 'too much' knowledge. But was the patient the only source of the problem?

The group worked hard on the follow ups, some of which were becoming familiar to me, as doctors fed in more grounded understanding of their patients. Predictably, though, the task of changing attitudes was more elusive; doctors were often stuck in their feelings about a patient. Dr Caernarvon wondered: *'Lots of these cases in Balint groups are about doctors who are frustrated and don't know what to do any more with patients who don't listen and who have their own preconceived ideas. At what stage do you say "I've done my bit, I've contacted the relatives and spoken to the social worker and the other GP"?'*

Ultimately, Dr Adamson suggested, this was a decision that could only come from within. Doctors were covered so long as the basics were accurately recorded, should anything untoward transpire. Wasn't this the essence of Balint training: *'helping doctors decide where ordinary professional and moral responsibilities slipped into defensive behaviour?'* It was an overt teaching moment, time for facilitation to take a back seat – a discerning move given the previous disagreement. But had power relations subtly shifted in the process?

Group harmony had been restored with scarcely a ripple. I wondered if it was too good to be true. *'It all depends on what's going on underneath'*, Dr Scorso commented. Or in the interstices?

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Talking with both course organisers on my last visit suggested that the upset had been a *'difference of opinion'*: a routine happening, rather than indicating any rift within the group. Dr Adamson felt I had overplayed its significance, and found it hard to recognise the interpretation I'd given of events. Was this because I hadn't 'got it' (the ethnographer's endless worry), or did Dr Adamson's difficulties resemble my own struggles in thinking with a different idiom? Dr Scorso disagreed and said she *'liked the cases and felt comfortable with them'*.

There had been no further comments that day by doctors in the group about giving advice. What shape any disagreement might take in future remains to be seen.

Discussion

Both groups were good sessions, sensitively and expertly led. But what had happened between the two?

Superficially the disagreement in the first group revolved around silencing the clinical narrative, a familiar story. When resistance often takes culturally patterned forms, in this sense nothing unusual was happening.

When the words we use are often prototypes for something else, what people disagree about openly is often not 'the facts of the case' but an official version of events that may be less problematic than the truth. Disorder had momentarily threatened and been explained away. What were the group learning about disagreement in a professional culture where, as one registrar put it, *'you learn to keep your mouth shut, and if you're a woman you keep it shut even more!'*? How far could the Balint process itself be questioned, particularly in this context? Was there space to ask, and continue to ask, why?

The drama being played out in the second group showed how social contradictions are always experienced as personal problems. Health promotion messages demand that patients become 'risk aware', yet the knowledgeable patient may receive a cool reception when doctors fear that their clinical expertise seems to be sidelined. Both doctor and patient were caught up in forces not of their

own making, simultaneously promoting healthy living and struggling with its less desirable consequences. The difficult question of when to advise (as doctors were strongly encouraged to do in a session on alcoholism attended earlier in the year) and when to 'think Balint' was likely to be an intuitive matter, only resolvable with experience. Unseen, too, were the power dynamics between patient and doctor; in being drawn into a *'he can have this but not that'* dilemma, it was the patient as much as the doctor who was becoming de-skilled. Difficult to acknowledge was the way that doctors were also 'demanding' of patients.

Both groups illustrate the contradictory nature of facilitation when it involves fine judgements about when and how far to play it. Getting Balint to 'take' meant course organisers needed to work around the formal characteristics of Balint work rather than apply them too rigidly. The task of weathering any criticism of what they had to offer demanded a particular maturity.

Doctors' summary comments about Balint and non-Balint group learning

We conclude this section with some quotations from some of the participants in the two groups, selected to give the range of responses not always articulated within the case studies.

Highville (Balint)

It's got rules of its own that no other presentation has. We're able to expose the case the way we want. We get asked questions about it, but then we withdraw from the group. The 'pull-outs' are unique – I've never met that before.

Sometimes you say things and you feel very misunderstood – 'ooooh'! Although one of the things about structuring it like this is that that's less *likely to happen.*

I've found that it makes me more open-minded and tolerant – patients you might easily dismiss as difficult patients. It's quite easy, especially when you're rushed, to fall into the trap of quickly stereotyping. Balint continually brings you back to being a bit more open-minded, lateral in your thinking about a person's situation.

I do find it difficult being so directed. It's about being led away from where the discussion might naturally go. People are doing it because they're trying to be true to Balint, whatever Balint is. I think in some contexts that's useful, in others it's important to be flexible.

It's a creative process rather than a deductive one. A lot of groups are breaking things down and analysing – well we break things down and analyse but it's more generating ideas rather than narrowing things down. It probably opens up more questions than it answers, whereas a lot of group work is on a Q. and A. basis.

I'm uncomfortable with any ideological concept. There's a feeling of rightness about it. It strikes me someone has decided that Balint is the right thing for registrars to do to broaden their minds, and I don't quite understand if it's the right thing for registrars to do, why it should be the only *right thing, because there isn't an 'only one right thing' for most things in life.*

It's also reassuring to know that people have emotional difficulties. A lot of doctors only speak about their diagnostic difficulties – 'I had this patient, didn't have a clue what was wrong.' But to actually discuss the things you take home with you, the baggage at the end of the day, it's very refreshing.

I don't think it's patient-centred. We're doctors, coming to sit in this group. There are no patients. Having doctors talking about patients cannot be patient-centred. But things have gone too far the other way. We're always talking about patients.

I worry that it's empty sometimes, that there's a sort of emptiness behind the thoughts. Is it something you've thought about and are actually feeling with the protagonist? Are they saying things like 'Well it could be this, it could be that . . . ' or are they saying 'Well if I'd have thought of this that would have led me to this . . . '? I can't put the arguments very well.

I think you can be open in terms of your feelings and emotions about the case, but you can't be open as to your true, fundamental beliefs. They can't be openly aired. . . . And there's always a slight amount of 'Well, did you do this?' 'Did you ask them that?' It's almost like saying 'I think you should *have asked them this or that. Why didn't you?' I've been doing my own personal counselling for two years so for me it's familiar – well it's not the same as counselling, but there's something about people opening up and you sharing things or showing their vulnerability. It's just a continuation of that really. Group work does just get thrown at you. We're not asked whether that's what we want or not.*

The discussion time is very rich for me. It suddenly brings other ideas to my mind about what I could do, what I need to do, whether I should have done something different and what I'm going to do in future for this patient. It's very useful.

Perhaps the question you should be asking is 'If it's so good, why hasn't it been taken up more outside VTS?' I do wonder if there's some elitism to it. That's why they're keeping it as it is, in an unadulterated form, uninfluenced by modern thinking. Personally I think that's not doing anyone any good really. If it becomes so exclusive and contained that it can't grow, then it's making trouble for itself. You see I like exploring, I like discussion, particularly postulating and hypothesising. I'd probably enjoy any group work

like we're doing. Whether it's Balint or not probably doesn't really matter to me.

Jamestown (non-Balint)

The group's very cohesive and it's a safe haven. It's very helpful and reassuring to have that safety and comfort. And getting things off your chest and finding that other people don't know the answer either.

It's how you deal with this situation. *It's about reflecting on the work you're doing and sharing those thoughts with other people without fear of being laughed at or criticised. And it's somewhere where people have got time for you.*

Learning, it's an ongoing thing definitely, not a set of end-points. And your understanding of it changes too – it's a question of outlook rather than 'I know what to do with this, this and this'.

The balance of teaching and spontaneous stuff – most of my colleagues agree that it's gone a bit too far the other way.

People tend to become more like each other in the group. Strange really, if you're not told you must do this, you kind of, well, you ought to really. And that perhaps has a stronger influence.

It's disconcerting, because all the time you're gaining knowledge you're losing it too.

I felt very much it's the sort of thing I do with one of my girl friends on a Friday night. It's talking about problems you've had at work. So for me it felt like – well not a repetition, but something I'd naturally be doing anyway.

We did want to be taught a little more, more kind of hard facts. I think we all felt really overwhelmed when we started with the vast clinical problems we were meeting and not knowing how to cope with the clinical things, whereas a lot of VTS are about communication and practice matters. We were all saying 'Hang on a minute! I can't even tell a patient what's wrong with her, never mind doing it nicely!' So we probably had different expectations from what the course organisers wanted.

It's quite useful just to see how your colleagues at a similar level of experience as you approach a problem. It's a way of assessing whether your own way of approaching a case is standard or not standard. How shall I put it, you feel OK, you're doing things similarly, and there's a kind of reassurance about it, that you have problems in the same way as other people have problems.

The patient is present, very, very present, but not there if you see what I mean. That's something worth reflecting on, because it reminds you about respect.

They're very cohesive. It's a safe haven to a certain extent. You often store a lot of things up and become quite pent up. It's very reassuring to have that safety valve, getting things off your chest. And finding that other people don't know all the answers either.